§ 154.301  CMS's determinations of Effective Rate Review Programs.

(a) Effective Rate Review Program. In evaluating whether a State has an Effective Rate Review Program, CMS will apply the following criteria for the review of rates for the small group market and the individual market, and also, as applicable depending on State law, the review of rates for different types of products within those markets:

(1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.

(2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.

(3) The State's rate review process includes an examination of:

(i) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions.

(ii) The health insurance issuer's data related to past projections and actual experience.

(iii) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.

(iv) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.

(v) The examination must take into consideration the following factors to the extent applicable to the filing under review:

(i) The impact of medical trend changes by major service categories.

(ii) The impact of utilization changes by major service categories.

(iii) The impact of cost-sharing changes by major service categories, including actuarial values.

(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.

(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.

(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.

(vii) The impact of changes in reserve needs.

(viii) The impact of changes in administrative costs related to programs that improve health care quality.

(ix) The impact of changes in other administrative costs.

(x) The impact of changes in applicable taxes, licensing or regulatory fees.

(xi) Medical loss ratio.

(xii) The health insurance issuer's capital and surplus.

(xiii) The impacts of geographic factors and variations.

(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.

(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

(4) The examination must take into consideration the following factors to the extent applicable to the filing under review:

(i) The impact of medical trend changes by major service categories.

(ii) The impact of utilization changes by major service categories.

(iii) The impact of cost-sharing changes by major service categories, including actuarial values.

(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.

(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.

(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.

(vii) The impact of changes in reserve needs.

(viii) The impact of changes in administrative costs related to programs that improve health care quality.

(ix) The impact of changes in other administrative costs.

(x) The impact of changes in applicable taxes, licensing or regulatory fees.

(xi) Medical loss ratio.

(xii) The health insurance issuer's capital and surplus.

(xiii) The impacts of geographic factors and variations.

(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.

(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

(5) The State's determination of whether a rate increase is unreasonable.
Department of Health and Human Services

is made under a standard that is set forth in State statute or regulation.

(b) Public disclosure and input. In addition to satisfying the provisions in paragraph (a) of this section, a state with an effective rate review program must provide, for the rate increases it reviews, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS’s Web address for such information) and have a mechanism for receiving public comments on those proposed rate increases.

(c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

(d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State’s circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.

[76 FR 29985, May 23, 2011, as amended at 78 FR 13441, Feb. 27, 2013]

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

Subpart A—General Provisions

Sec.
155.10 Basis and scope.
155.20 Definitions.

Subpart B—General Standards Related to the Establishment of an Exchange

155.100 Establishment of a State Exchange.
155.105 Approval of a State Exchange.
155.106 Election to operate an Exchange after 2014.
155.110 Entities eligible to carry out Exchange functions.
155.120 Non-interference with Federal law and non-discrimination standards.
155.130 Stakeholder consultation.
155.140 Establishment of a regional Exchange or subsidiary Exchange.
155.150 Transition process for existing State health insurance exchanges.
155.160 Financial support for continued operations.
155.170 Additional required benefits.

Subpart C—General Functions of an Exchange

155.200 Functions of an Exchange.
155.205 Consumer assistance tools and programs of an Exchange.
155.206 Civil money penalties for violations of applicable Exchange standards by consumer assistance entities in Federally-facilitated Exchanges.
155.210 Navigator program standards.
155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under §§155.205(d) and (e) and 155.210 in a Federally-Incubated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant.
155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.
155.225 Certified application counselors.
155.227 Authorized representatives.
155.230 General standards for Exchange notices.
155.240 Payment of premiums.
155.260 Privacy and security of personally identifiable information.
155.270 Use of standards and protocols for electronic transactions.
155.280 Oversight and monitoring of privacy and security requirements.
155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.

Subpart D—Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

155.300 Definitions and general standards for eligibility determinations.
155.302 Options for conducting eligibility determinations.
155.305 Eligibility standards.
155.310 Eligibility process.
155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.
155.320 Verification process related to eligibility for insurance affordability programs.
155.330 Eligibility redetermination during the benefit year.
155.335 Annual eligibility redetermination.
155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.